

Personal Injury
Client Information Sheet

Today's Date: ____/____/____

Client Name –(Last, First,M.I.)

Client Phone Numbers: (Include Area Codes)

Cell/Pager:- (_____)_____

Home:- (_____)_____

Work:- (_____)_____

Email Address:- _____@_____

Calling
Instructions:_____

Client Street
Address:_____

City, State, Zip
Code:_____

Social Security
Number:_____

Drivers License
Number:_____

Client Date of Birth: ____/____/____ Age: _____

Date of Loss/Incident: ____/____/____ Time: _____

In Emergency
Contact:_____ Phone:_____

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How did you hear about us?

Yellow Pages:

_____ Yellow Book: Edition (Circle One) West Valley/Metro/East Valley/Scottsdale

_____ Internet: What Search Engine did you use? Google/Yahoo

Other _____

Friend? Who?

Motorcycle Promotion. Which one: _____

(For office use only: Case

Name: _____)

Marital Status: Single/Married/Divorced

Spouse's Name: _____

Your Employer: _____ **Address:**

Supervisor: _____

Occupation: _____ How Long:

Location of Incident:

City: _____

Responding Police: _____

DR#:

Hospitalized?: Yes No If so, at

TREATING PHYSICIANS/MEDICAL PROVIDERS:

1. _____

Phone #. _____

3. _____

Phone #. _____

5. _____

Phone #. _____

2.

Phone #.

4.

Phone #.

6.

Phone #.

WITNESSES TO ACCIDENT:

1. _____

2.

Phone #. _____

Phone #. _____

3. _____

4.

Phone #. _____

Phone #: _____

OTHER DRIVER:

Defendant "Driver": _____

Address: _____

Home #: ()

Work #: ()

Defendant Insurance Company:

Insurance Agent: _____ Phone #: ()

Policy #: _____ Coverage? Yes No

Claim #: _____

Address: _____

#. _____

Personal Injury Adjuster:

Address:

Phone #.

Property Damage Adjuster:

Company:

Address:

Phone

OTHER DRIVER/VEHICLE INFORMATION:

Defendant "**Owner**" (If different than Defendant Driver):

Name:

Address:

Home #: ()

Work #: ()

I n s u r a n c e

C o m p a n y :

Insurance Agent:

----- #.

Policy Number:

_____ Coverage? Yes

No

Claim Number:

Insurance Co. Address:

Phone #. _____

P e r s o n a l

I n j u r y

A d j u s t e r :

A d d r e s s :

P h o n e

:

P r o p e r t y

D a m a g e

A d j u s t e r :

YOUR INSURANCE INFORMATION:

I n s u r a n c e
Company: _____

A g e n t :

Policy Number:

Claim Number:

Coverage: Med-Pay

U M / U I M

Adjuster:

Address:

Phone #.

YOUR HEALTH INSURANCE INFORMATION:

I n s u r a n c e
Company: _____

Address:

Phone #.

A g e n t :

C l a i m

N u m b e r :

P o l i c y

N u m b e r :

ERISA Policy: Yes No

DETAILS OF ACCIDENT:

Description of facts leading up to accident/incident:

Did the accident occur during daylight? Yes _____ No _____

Were your headlights on? Yes _____ No _____

Were the other vehicle's headlights on? Yes _____ No _____

What were the weather conditions? clear _____ rain _____ fog _____ hail _____ snow
_____ freezing rain _____

If clear, did sun glare affect your vision? Yes _____ No _____

How was visibility? Good _____ Poor _____

If poor, were your wipers on? Yes _____ No _____
unknown _____

Was your windshield clear? Yes _____ No _____

Was the other vehicle's windshield clear? Yes _____ No _____
Unknown _____

Where did the accident happen? (Street name, route number, town, state, nearest cross street or landmark)

Describe the accident area: ___ residential ___ Commercial ___ Rural
___ other (Please describe) _____

If Auto accident, who was cited and for what:

Have you given a statement regarding the accident/incident? Yes No

If so, to whom?

Vehicle: Make _____ Model _____ Year

Present

location: _____

INJURIES:

Type of Injury

Treatment for Injury

1.

2.

3.

4.

5.

PAIN AND SUFFERING:

Describe all parts of your body in which the pain now manifests itself (start with the top of the head and work down):

Describe all parts of your body in which the pain first occurred:

Are any of the above symptoms an aggravation of a pre-existing condition: Yes No
If so, what was previous condition:

Description of frequency, duration, and severity of pain:

Describe which circumstances intensify pain:

Describe which circumstances lessen pain:

Describe any medication you are taking to lessen the pain:

Describe how you feel about your pain and what you do to cope with it:

Describe what ways your pain limits your activities regarding:

1. Work:

2. Hobbies:

3. Family:

4. Chores:

Describe any other symptoms associated with the pain (irritability, nausea, headache, stress, inability to move body parts, insomnia, body parts, etc.):

MEDICAL HISTORY:

Physical condition just prior to accident/incident:

Significant previous illnesses or physical problems (within last ten years):

Family Physician (name, address, and phone number):

Please list all medical providers seen in the past five

years: _____

Describe any prior accidents you have been involved in:

Have you ever been involved in a lawsuit or made a claim for injuries? Yes No
If so, describe the lawsuit or claim:

What is it that you expect your attorney to do for you:

LOST WAGES:

Have you missed time from work due to your injuries? Yes _____ No _____
If yes, what is your occupation? _____

How much time have you missed? _____

Please state your employer's name, address and phone
number: _____

Do you expect to be able to return to work? Yes _____ No _____ When?

LIENS:

(For Attorney's Use Only)

Provider	Amount
Reduced	

Costs

Provider

What

Amount

—

LOST WAGE STATEMENT

PLEASE PROVIDE ME WITH THE INFORMATION REQUESTED BELOW,
CONCERNING MY INJURY ON THE _____ DAY OF _____,
20____

Client

DATE:

NAME OF
COMPANY: _____

ADDRESS OF
COMPANY: _____

DATE OF
HIRE: _____

POSITION HELD BY
EMPLOYEE: _____

WAGE RATE: \$ _____ PER

AN OVERTIME OF
\$ _____ PER _____

TOTAL AMOUNT OF LOST
WAGES: _____

DATES OF ABSENCES SINCE EMPLOYEE'S
ACCIDENT: _____

Printed Name of Supervisor

Signature of Supervisor

Title of Supervisor

Signature of Employee

<http://mainmenu/FranklinandAssociates/office/PIclientinformationsheet-amended>